Supreme Court, U.S.
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No. ——

IN THE

Supreme Court of the United States

AMERICAN MEDICAL SECURITY, INC.,
Petitioner,

v.

SKILSTAF, INC.,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether Section 514(a) of the Employee Retirement Income Security Act ("ERISA") preempts state law claims, including a claim for punitive damages, brought by a self-funded employee benefit plan's sponsor against the plan's third-party administrator arising out of the administrator's processing of benefit claims.

2. Whether Section 514(a) of ERISA preempts state law claims, including a claim for punitive damages, based upon alleged self-dealing and conflicts of interest in the processing of benefit claims by a third-party administrator responsible for reviewing denied claims under an employee benefit plan's statutorily-mandated claims procedure.

PARTIES TO THE PROCEEDING BELOW

Plaintiff

Skilstaf, Inc.

Defendants

American Medical Security, Inc.

United Wisconsin Life Insurance Company

RULE 29.6 STATEMENT

Pursuant to Supreme Court Rule 29.1, Petitioner American Medical Security, Inc. discloses that its parent is American Security Holdings, Inc., which in turn is a wholly owned subsidiary of American Medical Security Group, Inc. Blue Cross and Blue Shield of Wisconsin owns 44.9 percent of American Medical Security Group, Inc.'s stock. Blue Cross and Blue Shield of Wisconsin is a wholly owned subsidiary of Cobalt Corporation.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner American Medical Security, Inc. ("AMS") respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Eleventh Circuit entered on March 9, 2001.

OPINIONS AND ORDERS BELOW

The unpublished decision of the court of appeals is reported at 251 F.3d 163 (table) and is reproduced in the Appendix ("App.") at 3a to 4a. The Eleventh Circuit's unpublished order denying AMS's petition for rehearing is available at 2001 U.S. App. LEXIS 15575 and is reproduced at 1a to 2a. The unpublished orders and judgment of the United States District Court for the Middle District of Alabama are reproduced at 5a to 48a.

JURISDICTION

The judgment of the court of appeals was entered on March 9, 2001. Its order denying Petitioner's timely petition for rehearing *en banc* was filed on May 4, 2001. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves Sections 3(21)(A)(iii), 404(a)(1)(A), 406(b), 502(a), 503, and 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1002(21)(A)(iii), 1104(a)(1)(A), 1106(b), 1132(a), 1133, and 1144(a), and 29 C.F.R. § 2560.503-1 promulgated under Section 503 of ERISA. These provisions are reproduced at 49a to 64a.

STATEMENT OF THE CASE

The sponsor of an employee benefit plan brought state law claims against AMS, a third-party administrator responsible for administering the plan's ERISA-mandated benefit claims

review procedure. The state law claims included claims for breach of fiduciary duty and "wantonness" based on AMS's alleged systematic delay in processing benefit claims to benefit itself financially. The case was tried before a jury in August 1999, the district court having previously rejected AMS's argument that ERISA preempted plaintiff's state law claims. The jury awarded plaintiff $6,902,576, which included $1,422,576 in compensatory damages on the fiduciary breach claim and $5,000,000 in punitive damages on the "wantonness" claim.

A. Facts

Respondent Skilstaf's predecessor, Stafco, Inc. (hereafter "Skilstaf"), established a self-funded employee benefit plan ("Plan") to provide health care benefits to its employees. In September 1992, Skilstaf entered into an Administrative Services Agreement ("Agreement") with petitioner AMS.

Under the Agreement, AMS agreed to prepare a summary plan description for the Plan's participants, secure excess loss insurance for Skilstaf, and perform certain administrative functions with respect to the Plan. AMS's administrative functions included: processing benefit claims; paying benefits from an account funded by Skilstaf; maintaining records and preparing reports of transactions between Skilstaf, AMS and Plan participants; pursuing subrogation claims; notifying participants of the reasons for claim denials and of their right to have the denials reviewed; and reviewing denied claims under a procedure designed to satisfy ERISA.

The summary plan description ("SPD") informed participants of their rights under the Plan and of AMS's procedures for processing and adjudicating claims. In an SPD section entitled "Statement of Your ERISA Rights," participants were informed that, "[w]ith respect to paying claims for benefits under this Plan, [AMS] shall have discretion to interpret policy terms, make decisions regarding eligibility and resolve factual questions."

Another SPD section, entitled "Claim Procedures," provided that participants would be notified of the decision on their claim for plan benefits within 30 days of AMS's receipt of the claim. The section also stated that participants would be informed of the reasons for any claim denial and given an explanation of the Claim Appeal Procedure. Later, under the heading "Legal Actions," participants were advised that, if a dispute arose:

> [AMS] will resolve such dispute by appropriate consideration of all available evidence. All determinations are conclusive, final, and binding; unless they are successfully appealed under the Claim Appeal Procedure. You cannot bring an action against the Plan or [AMS] at law or in equity to recover a claim or damages until more than 60 days after the Claim Appeal Procedure is completed. . . .

In another SPD section, entitled "Claim Appeal Procedure," participants were informed that an appeal request had to be sent to AMS within 60 days after receipt of a notice of claim denial. Participants would receive written notice of any decision within 60 days (in special circumstances, up to 120 days) of AMS's receipt of an appeal request. Participants then would have 60 days from the date they received this notice to request a second appeal to a special panel. The special panel was to notify participants in writing of its final decision within 60 days (in special circumstances, up to 120 days) of receiving the second appeal.

The SPD section describing the Claim Appeal Procedure concluded as follows:

> [AMS] will interpret the Plan, and determine all inquiries arising in the administration, application, and interpretation of the Plan in good faith and consistent with the Plan. In any case, you must exhaust all available appeals before taking any legal action.

The SPD did not establish, much less require participants to exhaust, a third-level appeal to Skilstaf.

The Agreement confirmed that no appeal to Skilstaf was contemplated. It provided that AMS (*not* the participants) would refer to Skilstaf:

> any disputed claim (*after the appeal process under the Plan has been completed*); any question of eligibility or entitlement of the claimant for coverage under the Plan; and any other question as AMS deems necessary. The PLAN SPONSOR acknowledges that any claim which it requests to be paid on an 'out-of-Plan' basis will not be considered Plan benefits reimbursable under the Excess Loss Insurance Policy.

(Emphasis added).

AMS arranged for Skilstaf to obtain excess loss insurance from United Wisconsin Life Insurance Company ("UWLIC"). AMS had a number of financial relationships with UWLIC, including a partial reinsurance arrangement through an AMS subsidiary.

Under the excess loss policy, UWLIC agreed to reimburse Skilstaf for "eligible medical claims under the Plan in excess of certain specific and aggregate amounts." However, UWLIC had no obligation to reimburse Skilstaf under the policy unless an expense was incurred and paid during the policy term. If the policy terminated during a policy term, no claims, including those already paid by AMS, would be eligible for excess loss coverage. By its express terms, the policy would terminate upon cancellation of Skilstaf's Agreement with AMS. Effective May 31, 1996 and prior to the end of the policy's term, Skilstaf canceled the Agreement, which resulted in termination of the excess loss policy.

B. Proceedings Below

On January 22, 1998, Skilstaf filed this action against AMS in the United States District Court for the Middle District of Alabama, invoking jurisdiction under 28 U.S.C. § 1332. Skilstaf's amended complaint included state law claims for breach of contract, negligence, "wantonness" and breach of fiduciary duty arising out of AMS's conduct in performing its administrative responsibilities with respect to the Plan. In the district court, Skilstaf maintained, among other things, that AMS intentionally delayed processing benefit claims to protect its subsidiary against excess loss liability as UWLIC's reinsurer. Skilstaf's claims for breach of fiduciary duty and "wantonness" were premised on this alleged conflict of interest and self-dealing. No ERISA claims were asserted against AMS.

In a summary judgment motion, AMS argued that Skilstaf's state law claims were preempted by ERISA. Skilstaf acknowledged that: "As an ERISA fiduciary of the Plan, Skilstaf could avail itself of the provisions of ERISA regarding breach of fiduciary duty by the Defendants and certainly has viable remedies under ERISA that it could pursue against the Defendants." Skilstaf, Inc.'s Response to Defendants' Reply Brief (June 18, 1999) at 3 n.3. Yet Skilstaf insisted that it could pursue "available state law remedies against the Defendants, although it certainly would not be precluded from asserting an ERISA cause of action against the Defendants in addition to its state law claims." *Id.*

In denying summary judgment, the district court rejected AMS's preemption argument, reasoning that "AMS is not an ERISA entity and the state law claims against it do not sufficiently relate to the employee benefit plan to be preempted by ERISA." App. at 33a. Skilstaf's state law claims were tried to a jury. AMS moved at the conclusion of the evidence for a directed verdict, again arguing that plaintiff's claims were preempted. The motion was denied,

and the jury returned a verdict against AMS for $6,902,576, including $6,422,576 in compensatory and punitive damages on the breach of fiduciary duty and "wantonness" claims. App. at 21a-22a. The district court thereafter denied AMS's motion for judgment as a matter of law, a new trial and/or remittitur, rejecting again AMS's argument that the state law claims were preempted. App. at 11a.

AMS appealed the district court's rulings to the United States Court of Appeals for the Eleventh Circuit. On March 9, 2001, a panel of the Eleventh Circuit affirmed the district court's rulings in an unpublished *per curiam* decision. App. at 3a-4a. AMS then filed a petition for rehearing *en banc*, which the Eleventh Circuit denied on May 4, 2001. App. at 1a-2a.

REASONS FOR GRANTING THE PETITION

This Court has taken notice of "the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force."[1] In enacting ERISA to protect the interests of participants and beneficiaries in these plans, Congress expressly intended to make employee benefit plan regulation a "matter of exclusive federal concern."[2] One of Congress's principal goals in drafting ERISA was the elimination of the conflicting system of state and local regulation then governing the employee benefit field.[3] In its place, Congress substituted a single federal regulatory scheme governing the operation and administration of employee benefit plans. ERISA, as finally enacted, imposes uniform standards of

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[1] *Boggs v. Boggs*, 520 U.S. 833, 839 (1997).

[2] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

[3] H.R. Rep. No. 93-533 at 12 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4650 ("H.R. Rep. No. 93-533"); 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams).

conduct on fiduciaries,[4] establishes a comprehensive civil enforcement scheme,[5] and requires every employee benefit plan to adopt an internal procedure for the orderly resolution of benefit claims.[6]

ERISA's preemption provision—referred to in the legislative history as the statute's "crowning achievement"[7]—was meant to ensure that this new federal framework remained preeminent. With narrow exceptions, ERISA § 514(a) expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ."[8] The "basic thrust" of this preemption provision is "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."[9]

Consistent with this objective, this Court has found state laws preempted where they purport to regulate the administration of plans or provide alternate enforcement mechanisms for breach of ERISA obligations.[10] Nonetheless, the scope of ERISA's preemption of state law has remained a source of confusion. Indeed, since its first foray into this area in 1981, this Court has been required to address ERISA's preemptive scope on eighteen separate occasions—most recently, last term in *Egelhoff v. Egelhoff ex rel. Breiner*, 121 S. Ct. 1322 (2001)—and already it has decided to hear still another ERISA preemption case on the merits this

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[4] ERISA §§ 401-14, 29 U.S.C. §§ 1101-14.

[5] ERISA § 502(a), 29 U.S.C. § 1132(a).

[6] ERISA § 503, 29 U.S.C. § 1133.

[7] 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent).

[8] 29 U.S.C. § 1144(a).

[9] *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995).

[10] *Id.* at 657-58.

term. *Rush Prudential HMO, Inc. v. Moran*, 230 F.3d 959 (7th Cir. 2000), *cert. granted*, 121 S. Ct. 2589 (2001).[11]

The Eleventh Circuit's decision once again calls on this Court to address this central feature of ERISA's statutory scheme, this time in the context of an important member of the employee benefit plan community—the third-party administrator. Respondent's state law claims—alleging that Petitioner failed to timely process benefit claims—intrude directly into the plan's "'system for processing claims and paying benefits'" and impose "'precisely the burden [on plan administration] that ERISA pre-emption was intended to avoid.'"[12] In addition, Respondent's breach of fiduciary duty and "wantonness" claims accused Petitioner of intentionally delaying the processing of claims to benefit itself financially. Such conduct is tantamount to an ERISA fiduciary "self-dealing" violation,[13] for which the remedies provided by ERISA's civil enforcement scheme were intended to be exclusive.[14]

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[11] *Moran* involves state intrusion into ERISA's regulatory framework and civil enforcement scheme (including the plan's claim review procedures) similar to that here presented—a provision of a state HMO law which requires disputes over medical necessity to be submitted to independent physician review. The Court also has called for the views of the Solicitor General in yet another ERISA preemption case in which a petition for certiorari is pending—*Kentucky Ass'n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000), *petition for cert. filed*, 69 U.S.L.W. 3646 (Mar. 22, 2001) (No. 00-1471) (whether ERISA preempts state "any willing provider" law). *See* 121 S. Ct. 2546 (2001) (interim order inviting the Solicitor General's views).

[12] *Egelhoff*, 121 S. Ct. at 1329 (quoting *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987)).

[13] *See* ERISA §§ 404(a)(1)(A) & 406(b), 29 U.S.C. §§ 1104(a)(1)(A), 1106(b).

[14] *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142-45 (1990) (participant's state common law claim alleging wrongful discharge to

The Eleventh Circuit's decision allowing these state law claims to survive undermines ERISA's comprehensive regulatory framework and the important principles of uniformity upon which it is based. Furthermore, it conflicts with this Court's ERISA preemption jurisprudence and the Fourth Circuit's decision in *Tri-State Machine, Inc. v. Nationwide Ins. Co.*, 33 F.3d 309 (4th Cir. 1994), *cert. denied*, 513 U.S. 1183 (1995). Finally, the case is illustrative of the numerous cases in the lower courts that have addressed ERISA's preemption of state law claims against third-party administrators with differing results and rationales. The intervention of this Court is essential to provide clarity on an issue of law that is of critical importance to a segment of the employee benefit plan community that is responsible for processing literally millions of claims for plan benefits annually.

I. THE ELEVENTH CIRCUIT'S DECISION ALLOWS STATE LAW STANDARDS TO INTRUDE INTO THE CLAIMS PROCEDURE MANDATED BY ERISA

The Eleventh Circuit's decision frustrates a central goal of ERISA's statutory framework—enabling the establishment of "'a uniform administrative scheme, which provides a set of standard procedures to guide [the] processing of claims and disbursement of benefits.'" *Egelhoff*, 121 S. Ct. at 1328 (quoting *Fort Halifax*, 482 U.S. at 9). Under Section 503 of ERISA, all employee benefit plans must establish claims procedures that comply with Department of Labor regulations. 29 U.S.C. § 1133; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 53 (1987); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 143-44 (1985). The regulation promulgated by the Department of Labor requires every

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prevent his attainment of plan benefits was preempted because it conflicted with ERISA's civil enforcement scheme).

employee benefit plan to establish "reasonable" claims procedures and specifies a host of conditions that must be satisfied. 29 C.F.R. § 2560.503-1(b).

Among other things, the Department's regulation requires plans to furnish participants with written notice of any claim denial within a reasonable time after the plan's receipt of the claim. 29 C.F.R. § 2560.503-1(e)(1). A time period exceeding 90 days is deemed unreasonable absent special circumstances. 29 C.F.R. § 2560.503-1(e)(3). If an extension of time is needed, written notice must be provided to the claimant within the initial 90-day period, and the extension itself cannot exceed 90 days. *Id.*

Under ERISA § 503(2) and 29 C.F.R. § 2560.503-1(g)(1), every employee benefit plan also is required to establish a procedure by which a claimant can obtain a "full and fair" review of an adverse benefit decision by "an appropriate named fiduciary." The Department's regulation provides that a decision on review must be made "promptly," ordinarily within 60 days after the plan's receipt of the request. 29 C.F.R. § 2560.503-1(h)(1)(i). If special circumstances require an extension of time, a decision on review must be rendered as soon as possible, but not later than 120 days after receipt of a request for review. *Id.*

The Plan's SPD in this case included a detailed description of its ERISA-mandated claims procedure.[15] The SPD

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[15] ERISA requires a summary plan description to be furnished to the plan's participants and beneficiaries. ERISA § 101(a)(1), 29 U.S.C. § 1021(a)(1); *see Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (purpose of summary plan description is "to communicate to beneficiaries the essential information about the plan"). This summary plan description must include, among other things, a description of the plan's procedures for presenting claims and the remedies available under the plan for redressing denied claims, including the claims procedures mandated by ERISA § 503. ERISA § 102(b), 29 U.S.C. § 1022(b); *see also* 29 C.F.R. § 2560.503-1(b)(1)(ii) (to be deemed

informed participants that they would be notified of the decision on their claim within 30 days of Petitioner's receipt of the claim. Under the Department's regulation, a participant's claim would be deemed denied if Petitioner failed to notify the participant of a denial within a "reasonable" time. 29 C.F.R. § 2560.503-1(e)(2). The SPD further informed participants that they could seek review of any denied claim through the Plan's Claim Appeal Procedure, and included a detailed description of the procedure and the applicable time frames.

The Eleventh Circuit's decision would allow state law standards to interfere with the claims procedure mandated by ERISA. Respondent's state law causes of action required Petitioner to adhere to an ill-defined "timeliness" standard in processing claims that was untethered to the time limits specified in the SPD and 29 C.F.R. § 2560.503-1. ERISA's pervasive regulation of the employee benefit plan claims procedure necessarily displaces state law causes of action like Respondent's alleging untimely processing of benefit claims.[16] The goal of ensuring uniformity in plan

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reasonable, claims procedures must be described in the summary plan description).

[16] In its new claims procedure rules under ERISA § 503, the Department of Labor expressly acknowledged the preemptive effect of its implementing regulation. The new rules, which become applicable at the earliest on January 1, 2002, specifically exclude certain state laws regulating insurance from the preemptive scope of the regulation. 29 C.F.R. § 2560.503-1(k) (effective Jan. 20, 2001); 65 Fed. Reg. 70,246, 70,254 (Nov. 21, 2000) (explaining subsection (k)); PWBA Press Release 01-31 (July 6, 2001) (extending date for group health plans to comply with new claims procedure rules), *available at* http://www.dol.gov/dol/pwba/public/media/press/pr070601.htm. Respondent's state law claims plainly are not laws regulating insurance within the meaning of the saving clause, ERISA § 514(b)(2)(A); *see, e.g., Pilot Life*, 481 U.S. at 48-52—nor would the saving clause apply to a self-funded plan such as the one at issue in this case. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

administration would be thwarted if third-party administrators like Petitioner could be required to comply with standards imposed by state law in processing benefit claims. *Fort Halifax*, 482 U.S. at 9. As this Court stated recently, "[r]equiring ERISA administrators to master the relevant laws of the 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff*, 121 S. Ct. at 1329 (quoting *Ingersoll-Rand Co.*, 498 U.S. at 142).

II. ALLOWING SPONSORS TO ASSERT STATE LAW CLAIMS FOR IMPROPER CLAIMS PROCESSING WOULD INHIBIT RESPONSIBLE DECISION-MAKING, INCREASE EMPLOYEE BENEFIT PLAN COSTS, AND DETER QUALIFIED PERSONS FROM PROVIDING ADMINISTRATIVE SERVICES TO PLANS

This Court has ruled that extracontractual damages cannot be awarded to participants under ERISA § 502(a)(2) based upon an administrator's improper processing of a claim for benefits. *Russell*, 473 U.S. at 148; 29 U.S.C. § 1132(a)(2).[17] The Court also has ruled that ERISA § 502(a)(3) authorizes only equitable relief, *not* money damages. *Mertens v.*

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[17] Having reviewed the statutory text and regulations relating to claims procedures, the Court in *Russell* found "nothing" to support a conclusion that delayed processing of claims gives rise to a cause of action for compensatory or punitive damages under ERISA. *Russell*, 473 U.S. at 144. Indeed, under the Department's regulation, the consequence at the initial processing stage of failing to notify a claimant of a denial within a reasonable time is that the claim is deemed denied, permitting the claimant to proceed to the "review stage." 29 C.F.R. § 2560.503-1(e)(2). Likewise, as the Court noted in *Russell*, the consequence of failing to furnish a claimant with a review decision promptly is that the claim is deemed denied on review. 29 C.F.R. § 2560.503-1(h)(4); *Russell*, 473 U.S. at 144.

Hewitt Assocs., 508 U.S. 248, 256-58 (1993); 29 U.S.C. § 1132(a)(3). In addition, emphasizing the "clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive," the Court has ruled that ERISA preempts a participant's state common law causes of action alleging improper processing of a claim for benefits. *Pilot Life*, 481 U.S. at 57.

Viewed in this context, the Eleventh Circuit's decision affirming an award of damages *to the sponsoring employer* under state law can only encourage administrators to place the interests of the employer above those of the plan and its participants when processing claims. The interests of the employer, of course, are likely to diverge from those of the plan and the participants whose claims are being processed, particularly in situations where the employer is ultimately responsible for funding the payment of benefits. Encouraging administrators like Petitioner to act in the interest of the employer would be contrary to one of ERISA's central purposes—to "insulate the trust from the employer's interest." *NLRB v. Amax Coal Co.*, 453 U.S. 322, 333 (1981). Furthermore, since administrators would face potential liability for any alleged harm suffered by the plan sponsor due to delays in processing participants' claims, such damage awards would encourage administrators to place a premium upon speed at the expense of the thorough, deliberate consideration of benefit claims contemplated by ERISA.

The allowance of punitive damages under state law only compounds the disruptive impact of the Eleventh Circuit's decision. Such awards, of course, serve no compensatory purpose, but represent mere windfalls to prevailing plaintiffs. *See Smith v. Wade*, 461 U.S. 30, 59 (1983) (Rehnquist, J., dissenting); *City of Newport v. Fact Concerts, Inc.*, 453 U.S. 247, 266 (1981); *Int'l Bhd. of Elec. Workers v. Foust*, 442 U.S. 42, 50 (1979). At the same time, such awards have rested on standards that are both ill-defined and unevenly

applied. *See TXO Prod. Corp. v. Alliance Resources Corp.*, 509 U.S. 443, 472-75 (1993) (O'Connor, J., dissenting); *Browning-Ferris Indus. v. Kelco Disposal, Inc.*, 492 U.S. 257, 281 (1989) (Brennan, J., concurring); *Smith*, 461 U.S. at 60 (Rehnquist, J., dissenting).

Lacking a consistent framework of analysis, courts have developed a variety of ad hoc tests to determine both the entitlement to, and the measure of, punitive relief. *See, e.g., BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 588-89 (1996) (Breyer, J., concurring); *Pac. Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 42-43 (1991) (O'Connor, J., dissenting); *Smith*, 461 U.S. at 60-64 (Rehnquist, J., dissenting). The arbitrary nature of these standards often fails to provide defendants with fair warning of the consequences of their actions, thus negating the primary purpose of punitive damage awards—deterrence of conduct which violates legal standards. *See, e.g., Gore*, 517 U.S. at 574-75; *Smith*, 461 U.S. at 59 (Rehnquist, J., dissenting).

The detrimental impact of this state of affairs on employee benefit plans is self-evident. Without a uniform federal standard, punitive damages are likely to fall unevenly upon those responsible for claims processing, depending upon the state in which they are sued. *See Cooper Indus. v. Leatherman Tool Group, Inc.*, 121 S. Ct. 1678, 1683 n.6 (2001); *Gore*, 517 U.S. at 613 n.6, 614-19 (Ginsburg, J., dissenting); *Smith*, 461 U.S. at 59-64 (Rehnquist, J., dissenting). Moreover, the broad discretion accorded to the trier of fact to set the amount of punitive damages must inevitably lead to inconsistent results, *see TXO*, 509 U.S. at 473-75 (O'Connor, J., dissenting), which cannot be squared with Congress's emphasis in ERISA on predictability and uniformity.[18] *See Int'l Bhd. of Elec. Workers*, 442 U.S. at 50-52.

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[18] H.R. Rep. No. 93-533, *supra* note 3, at 12, *reprinted in* 1974 U.S.C.C.A.N. at 4650 ("The uniformity of decision which the Act is

Subjecting administrators like Petitioner to punitive damages would unsettle the delicate balance of costs and protections reflected in ERISA. The prospect of substantial, unpredictable punitive damage awards would increase the cost of providing administrative services to employee benefit plans. These costs inevitably would be passed back to the plans in the form of increased fees, to the ultimate detriment of the plans' participants and beneficiaries. *See Mertens*, 508 U.S. at 262 (exposing non-fiduciary service providers to liability for consequential damages would "impose high insurance costs upon persons who regularly deal with and offer advice to ERISA plans, and hence upon ERISA plans themselves."). Because of the difficulty of obtaining insurance coverage for punitive damages, many qualified persons would be deterred from providing administrative services to employee benefit plans. *See Browning-Ferris*, 492 U.S. at 282 (O'Conner, J., dissenting). These predictable results would frustrate Congress's goal of minimizing the costs and burdens imposed on employee benefit plans in order to promote their growth. *See Mertens*, 508 U.S. at 262-63; H.R. Rep. No. 533, *supra* note 3, at 1, *reprinted in* 1974 U.S.C.C.A.N. at 4639-40 (projected cost of each provision of ERISA analyzed in relation to anticipated benefit).

III. THIS COURT'S GUIDANCE IS NEEDED TO RESOLVE CONFUSION OVER THE APPLICATION OF ERISA PREEMPTION TO STATE LAW CLAIMS AGAINST THIRD-PARTY ADMINISTRATORS

The Eleventh Circuit's decision in this case conflicts with *Pilot Life* and with the Fourth Circuit's decision in *Tri-State Machine*. This Court ruled in *Pilot Life* that state common

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designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.").

law causes of action alleging improper processing of a claim for benefits "undoubtedly" met the criteria for ERISA preemption. *Pilot Life*, 481 U.S. at 57. Relying on *Pilot Life*, the Fourth Circuit held in *Tri-State Machine* that ERISA preempted a plan sponsor's state law claims against a third-party administrator under circumstances similar to those presented here. As in this case, the sponsor alleged that a third-party administrator of its self-funded plan delayed processing benefit claims to avoid coverage under a stop-loss insurance policy issued by the administrator. *Tri-State Machine,* 33 F.3d at 314. In holding that ERISA preempted the sponsor's state law claims, the Fourth Circuit reasoned that the state claims were "essentially complaints about the processing of claims under an employee benefit plan and, therefore, *relate to* the plan in the common sense meaning of that phrase." *Id.*

Resolution of this conflict is of critical importance to third-party administrators of self-funded employee benefit plans. In a self-funded plan, the employer (or trust in the case of a multiemployer plan) pays the benefit claims of plan participants out of its own assets. *See FMC Corp.*, 498 U.S. at 61-62 (distinguishing between insured and self-funded plans). A recent study estimated that 47.9 million individuals (39% of those in private sector, employment-based health plans) were enrolled in self-funded private sector, employment-based health plans in 1997. Employee Benefits Research Institute, *Employment-Based Health Care Benefits and Self-Funded Employment-Based Plans: An Overview* at 6 (Apr. 2000).[19] These self-funded plans typically are administered by a third-party administrator, which may be an insurance company or other independent organization that specializes in the provision of administrative services to plans. *See* Employee Benefits Research Institute, *Issue Brief No. 193*, at 18 (Jan. 1998).

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[19] *Available at* http://www.ebri.org/facts/0400fact.pdf.

Absent review by this Court, the Eleventh Circuit's decision can only exacerbate existing uncertainty about the application of ERISA's preemption provision to state law claims against third-party administrators. Preemption cases involving state law claims against third-party administrators are recurrent, and the case law reflects considerable confusion about the circumstances under which such claims may be preempted by ERISA. *See Geweke Ford v. St. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355, 1359-60 (9th Cir. 1997) (ERISA did not preempt plan sponsor's state law breach of contract claim against third-party administrator); *Coyne & Delany Co. v. Selman*, 98 F.3d 1457, 1471-72 (4th Cir. 1996) (ERISA did not preempt sponsor's state law professional malpractice claim against third-party administrator); *Tri-State Machine*, 33 F.3d at 313-14 (ERISA preempted plan sponsor's state law claims against third-party administrator); *Kyle Rys. v. Pac. Admin. Servs.*, 990 F.2d 513, 518-19 (9th Cir. 1993) (ERISA preemption of sponsor's state law claims against third-party administrator does not violate due process clause).[20] A decision by this Court would provide much

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[20] *See also Hughes Supply, Inc. v. Robey-Barber Ins. Servs.*, No. 99-2904-Civ-T-17C, 2000 WL 782954, at **5-7 (M.D. Fla. June 5, 2000) (ERISA preempted sponsor's state law action for conversion and breach of contract against third-party administrator); *Analytical Surveys, Inc. v. Intercare Health Plans, Inc.*, 101 F. Supp. 2d 727, 734-36 (S.D. Ind. 2000) (ERISA did not preempt sponsor's state law breach of contract and gross negligence claims against third-party administrator for delayed processing of benefit claims); *Tie Communications, Inc. v. First Health Strategies, Inc.*, No. Civ-A-97-2597-EEO, 1998 WL 171126, at **2-5 (D. Kan. Mar. 3, 1998) (ERISA did not preempt sponsor's state law breach of contract claim against third-party administrator for failure to provide stop-loss insurer with information about a participant's claim in a timely manner); *Hartford Fire Ins. Co. v. E.A. Sween Co.*, 920 F. Supp. 1021, 1028-29 (D. Minn. 1996) (ERISA preempted sponsor's state law breach of contract, negligence and bad faith claims against third-party administrator); *Union Health Care, Inc. v. John Alden Life Ins. Co.*, 908 F. Supp. 429, 435-36 (S.D. Miss. 1995) (ERISA did not preempt sponsor's state law claim against third-party administrator for failure to

needed clarity and guidance as to the duties and liabilities of third-party administrators under state and federal law in providing administrative services to self-funded plans.

IV. THE ELEVENTH CIRCUIT'S DECISION UNDERMINES CONGRESS'S INTENT TO PROVIDE UNIFORM STANDARDS OF FIDUCIARY CONDUCT AND EXCLUSIVE REMEDIES FOR FIDUCIARY BREACHES

Review of the Eleventh Circuit's decision is necessary to restore the primacy of federal regulation in the critical area of fiduciary standards. In enacting ERISA, Congress sought to establish a uniform federal regulatory scheme for evaluating fiduciary conduct. H.R. Rep. No. 93-533, *supra* note 3, at 12, *reprinted in* 1974 U.S.C.C.A.N. at 4650 ("[A] fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state.").[21] Congress accomplished this goal by formulating detailed federal standards to guide fiduciaries,[22] and by specifying the remedies available for enforcement of these fiduciary responsibility requirements. *See Varity Corp. v. Howe*, 516 U.S. 489, 507-09 (1996).

As this Court observed in *Varity*, an administrator is a fiduciary under ERISA to the extent it makes discretionary decisions about whether participants are entitled to benefits under a plan's terms. *Varity*, 516 U.S. at 511; ERISA

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notify stop-loss carrier in a timely manner); *Fox, Curtis & Assocs. v. Employee Benefit Plans, Inc.*, No. 92-C-5828, 1993 WL 265474, at **3-6 (N.D. Ill. July 13, 1993) (ERISA did not preempt sponsor's state law breach of contract and Illinois Consumer Fraud and Deceptive Practices Act claims against third-party administrator).

[21] *See also* 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams); *id.* at 29,197 (remarks of Rep. Dent).

[22] See ERISA §§ 401-14, 29 U.S.C. §§ 1101-14.

§ 3(21)(A)(iii), 29 U.S.C. § 1002(21)(A)(iii).[23] Under the SPD's written terms, Petitioner was an ERISA fiduciary because it was the entity responsible for reviewing denied claims.[24] Indeed, ERISA provides expressly that a participant must be afforded a reasonable opportunity for such review by an "appropriate named *fiduciary*." ERISA § 503(2), 29 U.S.C. § 1133(2) (emphasis added). According to the Department of Labor, a person is a fiduciary to the extent such person has "final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions relating to eligibility for benefits." 29 C.F.R. § 2509.75-8, Q-D-3. And the Department has made clear that a person who reviews denied claims under ERISA § 503(2) "must [have] authority to make a final decision on the claim." 42 Fed. Reg. 27,426, 27,426 (May 27, 1977) (preamble to 29 C.F.R. § 2560.503-1).[25]

Respondent's state law breach of fiduciary duty and "wantonness" claims accused Petitioner of intentionally delaying the processing of claims for its own financial benefit—conduct which amounts to ERISA disloyalty, conflict of interest, and self-dealing violations. As an ERISA fiduciary, Petitioner had a duty under ERISA § 404(a)(1)(A) to act "solely in the interest" of the plan's participants and

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[23] *Cf. Pegram v. Herdrich*, 530 U.S. 211, 228-37 (2000) (HMO physicians' "mixed" eligibility and treatment decisions are not fiduciary decisions under ERISA).

[24] *See, e.g., Reich v. Lancaster*, 55 F.3d 1034, 1047 (5th Cir. 1995) (third-party administrator may be an ERISA fiduciary if it has the authority to "grant, deny, *or review denied claims*") (emphasis added).

[25] That the SPD did not describe any procedure for appealing a denied claim to Respondent demonstrates that a decision by Petitioner on review was final for purposes of exhausting all remedies available under the plan. *See, e.g., Russell*, 473 U.S. at 144 (consequence of deeming a claim denied on review is that the claimant can "bring a civil action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits").

beneficiaries and for the "exclusive purpose" of providing benefits and defraying reasonable expenses of administration.[26] *See Pegram*, 530 U.S. at 223-25. Petitioner also was subject to the prohibited transaction provisions of ERISA § 406(b), which proscribe fiduciary conflicts of interest and self-dealing.[27] *See Lockheed Corp. v. Spink*, 517 U.S. 882, 888 (1996); *Russell*, 473 U.S. at 143 n.10.

ERISA's civil enforcement scheme provides a host of remedies for these alleged fiduciary violations.[28] For example, the remedies available under ERISA § 409(a) include restoration of all losses resulting to the plan,[29] restitution of ill-gotten profits,[30] and "other equitable or

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[26] 29 U.S.C. § 1104(a)(1)(A).

[27] The prohibitions of ERISA § 406(b), 29 U.S.C. § 1106(b), are designed to deter fiduciaries "from exercising the authority, control, or responsibility which makes [them] fiduciaries when they have interests which conflict with the interests of the plans for which they act." 29 C.F.R. § 2550.408b-2(e)(1).

[28] As noted earlier, in opposing Petitioner's summary judgment motion, Respondent acknowledged that it could pursue such remedies against Petitioner. *See supra* at 5.

[29] *See, e.g., Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut.*, 982 F.2d 1031, 1034-39 (6th Cir.) (complaint against third-party administrator stated ERISA claim for an accounting and restitution of improperly paid nursing-home claims), *cert. denied*, 510 U.S. 819 (1993); *cf. Harold Ives Trucking Co. v. Spradley & Coker, Inc.*, 178 F.3d 523 (8th Cir. 1999) (third-party administrator liable under ERISA § 409 for breach of fiduciary duty in failing to notify plan administrator that stop-loss insurer had denied coverage of claim).

[30] *See, e.g., Am. Fed'n of Unions Local 102 Health & Welfare Fund v. Equitable Life Assurance Soc'y*, 841 F.2d 658, 662-64 (5th Cir. 1988) (third-party administrator liable under ERISA § 409 for benefits paid to ineligible claimants and for commissions earned on improper benefit payments); *The Sixty-Five Sec. Plan v. Blue Cross & Blue Shield*, 583 F. Supp. 380, 388 (S.D.N.Y. 1984) (ERISA complaint stated fiduciary conflict of interest claim against third-party administrator for allegedly overpaying claims to increase its fees).

remedial relief as the court may deem appropriate," including removal of the fiduciary.[31] *See Mertens*, 508 U.S. at 252-53. Appropriate equitable relief also is available under ERISA § 502(a)(3). 29 U.S.C. § 1132(a)(3); *see Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 250-53 (2000). And in such actions, a court in its discretion may allow an award of attorney's fees and costs to either party under ERISA § 502(g).[32] 29 U.S.C. § 1132(g); *see Pilot Life*, 481 U.S. at 53.

Unless reversed, the Eleventh Circuit's decision will undermine this comprehensive regulatory framework and the important principles of uniformity on which it is based. *See Ingersoll-Rand Co.*, 408 U.S. at 145 (ERISA preempts state law cause of action purporting to provide alternate enforcement mechanism for breach of an ERISA obligation). Respondent's state law claims not only attempt to regulate the conduct of an ERISA fiduciary, but also are in direct conflict with ERISA's fiduciary responsibility requirements. In particular, Respondent's claims of breach of fiduciary duty and "wantonness" purport to require Petitioner to carry out its administrative functions in compliance with state law duties of care and loyalty owed to Respondent in its capacity as *employer*. These state law duties plainly conflict with ERISA's duty of loyalty, which requires Petitioner to act with "'an eye single' toward [the plan] beneficiaries' interests." *Pegram*, 530 U.S. at 235 (quoting *Donovan v. Bierwirth*, 680

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[31] *See Russell*, 473 U.S. at 147 ("If the plan administrator's refusal to pay contractually authorized benefits had been willful and part of a larger systematic breach of fiduciary obligations, [the plan participant] . . . could have asked for removal of the fiduciary pursuant to §§ 502(a)(2) and 409.").

[32] Additionally, the Secretary of Labor may assess a civil penalty against a breaching fiduciary under ERISA § 502(l).[32] 29 U.S.C. § 1132(l); *see Harris Trust & Sav. Bank.*, 530 U.S. at 248; *Mertens*, 508 U.S. at 259-61.

F.2d 263, 271 (2d Cir. 1982)). By affirming a judgment against Petitioner for allegedly breaching these purported state law duties owed to Respondent, the Eleventh Circuit's decision can only frustrate Congress's intent to establish a uniform federal law for evaluating fiduciary conduct. *See Fort Halifax*, 482 U.S. at 11.

V. THE QUESTIONS PRESENTED BY THIS PETITION HOLD IMPORTANT IMPLICATIONS FOR THE INTEGRITY OF THE CLAIMS PROCESSING FUNCTION PERFORMED ON BEHALF OF EMPLOYEE BENEFIT PLANS

The Department of Labor has estimated that there are now more than 6 million private employee benefit plans covering approximately 150 million people and controlling more than $5 trillion in assets. U.S. Dep't of Labor, Pension & Welfare Benefits Administration, *Annual Performance Plan—Fiscal Year 2002*.[33] More than 2.5 million of these plans are group health plans providing coverage to more than 125 million participants and making benefit-related expenditures in excess of $250 billion annually. *Id.* Many of these plans, moreover, are multi-state in operation.

Claims processors for employee benefit plans can be expected to process literally millions of claims for disability, pension and health benefits annually. Although the review of denied claims under a plan's ERISA-mandated claims procedure is necessarily a fiduciary function within the meaning of ERISA § 3(21)(A)(iii),[34] the Department of Labor has expressed the view that the initial "[p]rocessing of

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[33] *Available at* http://www.dol.gov/dol/pwba (accessed via library link).

[34] 29 U.S.C. § 1002(21)(A)(iii).

claims" may be a ministerial, non-fiduciary function.[35] Frequently, those who perform this initial "claims processing" function are either employees or agents of the person who serves as the plan's claims review fiduciary under ERISA § 503(2).

Because these persons are fiduciaries only "to the extent" that they perform one of the functions listed in ERISA § 3(21)(A)(iii), *see Pegram*, 530 U.S. at 225-26, the Eleventh Circuit's decision creates confusion as to whether such persons may be liable to plans or plan sponsors under state law for improper processing of claims. *Cf. Mertens*, 508 U.S. at 261 (assuming without deciding that ERISA preempts state law claims against non-fiduciaries for knowing participation in a fiduciary breach); *id.* at 267 n.2 (White, J., dissenting). A decision by the Court is necessary to provide guidance to these persons as to their respective duties and liabilities under state and federal law in the performance of this initial "claims processing" function. This Court's intervention is critical to restore the carefully crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's civil enforcement scheme in a core area of plan administration.

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[35] *See* 29 C.F.R. § 2509.75-8, Q-D-2 and Q-D-3.

CONCLUSION

For the reasons stated above, this Court should grant AMS's petition for a writ of certiorari and reverse the decision of the United States Court of Appeals for the Eleventh Circuit.

Respectfully submitted,

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